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Licensure of Health Care Professionals: The Consumer's Case for Abolition

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ABSTRACT

While state medical licensure laws ostensibly are intended to promote worthwhile goals, such as the maintenance of high standards in health care delivery, this Article argues that these laws in practice are detrimental to consumers. The Article takes the position that licensure contributes to high medical care costs and stifles competition, innovation and consumer autonomy. It concludes that delicensure would expand the range of health services available to consumers and reduce patient dependency, and that these developments would tend to make medical practice more satisfying to consumers and providers of health care services.

> I don't know that I cared much about these osteopaths until I heard you were going to drive them out of the State; but since I heard this I haven't been able to sleep . . . . Now what I contend is that my body is my own, at least I have always so regarded it. If I do harm through my experimenting with it, it is I who suffer, not the State.
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> Mark Twain

I. INTRODUCTION

Twenty-two years ago, economist Milton Friedman said of medical licensure:

> I am myself persuaded that licensure has reduced both the quantity and the quality of medical practice; that it has reduced the

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> opportunities available to people who would like to be physicians, forcing them to pursue occupations they regard as less attractive; that it has forced the public to pay more for less satisfactory medical service, and that it has retarded technological development both in medicine itself and in the organization of medical practice. I conclude that licensure should be eliminated as a requirement for the practice of medicine.[1]

At the time, Friedman's idea might have seemed a shocking example of the Social Darwinistic extremes to which too much devotion to free market economics could lead. But one need not subscribe to the theories of the Chicago school of economics to conclude that the time has come to do away with medical licensure. Michael Pertschuk, a Federal Trade Commissioner and long-time consumer advocate, added his voice five years ago to Professor Friedman's:

> Licensing boards, dominated by members of the profession, may act like any other cartel . . . .
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> [L]ike medieval guilds, the licensed professions can maintain their privileged positions regardless of market forces. Study after study has shown that licensing results in higher direct costs to consumers. Indirect costs, in the form of foregone innovation and experimentation are higher still.[2]

This Article attempts to show that the disadvantages of maintaining a regime of health care licensure far outweigh the advantages. It traces this country's history of experimentation with licensure and examines how licensure has contributed to increasing health care costs. It argues that licensure has failed its goal of protecting the consumer of medical services from low quality medical care, and instead limits the consumer's freedom to choose alternative services which may be more effective as well as less expensive than those now available. The Article then discusses how modern medical care institutions might respond to delicensure and to these alternative services, and identifies forces presently at work in our society which make the abolition of licensure a realistic possibility.

II. THE BACKGROUND OF PROFESSIONAL HEALTH CARE LICENSURE

Licensure of health care professionals in the United States is a relatively recent phenomenon, dating only from the late nineteenth and early

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[1] M. FRIEDMAN, CAPITALISM & FREEDOM 158 (1962).

[2] Pertschuk, *Professional Licensure,* 43 CONN. MED. 793, 794 (1979).

twentieth centuries.[3] Prior efforts to regulate the practice of medicine in the United States had failed.[4] Shryock, a defender of medical licensure, described the period before licensure gained popularity:

> Unfortunately, the promise of early American [physician licensure] laws proved illusory, and for a half a century after 1820 licensing requirements apparently deteriorated. By the 1850s . . . the situation in the United States seemed to be approaching its nadir . . . .
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> [S]ectarian colleges—homeopathic, eclectic, "botanic"—invaded the country after 1830 and did battle with "regular" schools of any type. Obviously, ill-informed legislatures still thought one sort of medical practice as promising as another: a practical and equalitarian people could decide for themselves which type was most effective. When doctors protested against irregular practice they were accused of seeking a monopoly for their own benefit. Dr. N. S. Davis later claimed that the sects invented this accusation after 1840, in their crusade for medical freedom as analogous to religious freedom, but the evidence for earlier distrust of monopoly is clear enough. The sectarians doubtless stirred up old fears, condemning what they termed "orthodox intolerance." Moreover, the more learned sects—homeopathy and eclecticism—could then make a better plea for heresy on medical grounds than was to be the case a few decades later.[5]

The limited success of early licensure initiatives might have been due in part to legislators' lack of information about different approaches to medical care, but it certainly reflected as well the character of the American people of the period. In the 1830's, Alexis de Tocqueville observed, "The inhabitant of the United States learns from birth that he must rely on himself to combat the ills and trials of life . . . . [H]e is restless and defiant in his outlook toward the authority of society and appeals to its power only when he cannot do without it."[6]

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[3] R. SHRYOCK, MEDICAL LICENSING IN AMERICA 1650-1965, at 45-49 (1967). *See also* B. SHIMBERG, B. ESSER, & D. KRUGER, OCCUPATIONAL LICENSING: PRACTICES AND POLICIES 12-16 (1972); R. DERBYSHIRE, MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES 7-12 (1969); Sigerist, *The History of Medical Licensure,* 104 J. A.M.A. 1057 (1935).

[4] R. SHRYOCK, *supra* note 3, at 17-27.

[5] *Id.* at 27-29.

[6] A. DE TOCQUEVILLE, DEMOCRACY IN AMERICA 189 (1969). John Stuart Mill captured this pervasive sense of personal autonomy:

> [T]he sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be com-

This attitude of personal autonomy eventually yielded.[7] As scientific progress accelerated, health care delivery took forms which seemed beyond the means and capacities of the common man. The benefits of the new technology seemed available only at the cost of delegating decisions previously made by the individual to an elite corps of specially-trained technocrats. In his recent book, sociologist Paul Starr described the shifting mood:

> [By the mid-nineteenth century,] American politics and culture had undergone a deep change. The American faith in democratic simplicity and common sense yielded to a celebration of science and efficiency .... Both the Jacksonians and the Progressives esteemed science, but they understood it in different ways: The Jacksonians saw science as knowledge that could be widely and easily diffused, while the Progressives were reconciled to its complexity and inaccessibility .... The assumptions of radicals, reformers and conservatives reflected the more general decline of confidence in the ability of the laymen to deal with their own physical and personal problems. The home medical advisors of the early twentieth century, unlike their predecessors a half century earlier, concentrated mainly on everyday hygiene and first aid. By the Progressive era, to call for popular autonomy in healing was to endanger one's own credibility. The public granted the legitimate complexity of medicine and the need for institutionalized professional authority.[8]

Shimberg observes that licensure has been a transcendent phenomenon in the health professions since the beginning of the twentieth century: "Between 1910 and 1920, approximately 130 laws were passed regulating 14 health-related occupations. By 1970, 13 of these health-related occupations were being regulated by all fifty states."[9]

Physician licensure has reflected in large part a consumer willingness to entrust complex medical decisions to medical professionals. Licensure has in turn permitted the medical profession to monopolize the delivery of health care services, and to limit the scope of services that non-M.D.s can provide.[10] Although the profession's primary motive may have been the

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> pelled to do or forebear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise or even right .... In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

J. S. MILL, ON LIBERTY 9 (1978).

[7] R. SHRYOCK, *supra* note 3, at 47-48, 59-61.

[8] P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY 140-41 (1982).

[9] B. SHIMBERG, OCCUPATIONAL LICENSING: A PUBLIC PERSPECTIVE 15-17 (1980).

[10] Gellhorn, *The Abuse of Occupational Licensing,* 44 U. CHI. L. REV. 6, 11 (1976). *See also* E. RAYACK, PROFESSIONAL POWER AND AMERICAN MEDICINE: THE ECONOMICS OF THE AMERICAN

protection of the public, licensing laws have protected the profession as well. As Professor Gellhorn has pointed out:

> Licensing has only infrequently been imposed upon an occupation against its wishes. Unwelcomed licensure has indeed occurred .... In many more instances, however, licensing has been eagerly sought—always on the purported ground that licensure protects the uninformed public against incompetence or dishonesty, but invariably with the consequences that members of the licensed group become protected against competition from newcomers.[11]

Licensure has prevented non-M.D.s from competing freely in the market for medical services and has unreasonably restricted the variety of such services that is available to consumers.[12] Because of its anticompetitive tendencies, licensure has produced higher health care costs than those which would prevail in a competitive market.[13] Indeed, medical expenditures in the United States have soared astronomically in recent years. Health care expenditures accounted in 1982 for 10.5% of the Gross National Product,[14] compared with 5.3% in 1960.[15] Of the $322 billion spent on health care in 1982, public sources contributed 42%; consumers paid $175 billion directly or in conjunction with employers in the form of health insurance premiums.[16] The 1982 per capita expenditure for health care amounted to $1,365,[17] or nearly ten times the amount spent per person in 1960.[18]

Government has responded with layer upon layer of regulation designed to control costs. Since 1964, three out of four states have established "certificate of need" programs to regulate capital expenditures by health care facilities. The federal government has established health resource planning programs, and provides funding for state and local health planning agencies, which have substantial power to influence health care financing and spending decisions. Medicaid and Medicare reimbursement poli-

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MEDICAL ASSOCIATION (1967); M. FRIEDMAN, *supra* note 1, at 137-160; Kessel, *Price Discrimination in Medicine,* 1 J.L. & ECON. 20 (1958).

[11] Gellhorn, *supra* note 10, at 11.

[12] *See* Rayack, *Medical Licensure: Social Costs and Social Benefits,* 7 LAW & HUM. BEHAV. 147, 152-54 (1983).

[13] Frech, *The Long-Lost Free Market in Health Care,* in A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE 57 (M. Olson ed. 1981); *see also* M. FRIEDMAN, *supra* note 1, at 155 (other social costs). *See generally* P. FELDSTEIN, HEALTH CARE ECONOMICS 322-28 (1979).

[14] Gibson, Waldo & Levit, *National Health Expenditures, 1982,* 5 HEALTH CARE FIN. REV. 1, 19 (1983).

[15] *Id.* at 4; *see Factors Responsible for Increasing Cost of Medical Care,* 44 CONN. MED. 447 (1980).

[16] Gibson, Waldo & Levit, *supra* note 14, at 1.

[17] *Id.*

[18] The per capita expenditure in 1960 was $146. *Id.* at 4.

cies and participation requirements are also integral parts of the government's cost containment strategy.[19]

In addition, the Federal Trade Commission (FTC) has initiated numerous challenges to anticompetitive practices in the medical profession. The FTC recently secured a judgment barring the American Medical Association and its state affiliates from forbidding member doctors from advertising.[20] It obtained consent orders against medical groups which boycotted health maintenance organizations,[21] and brought suit against a state medical society for attempting by boycott to set fees paid by Blue Shield and the state Medicaid program for medical services.[22] Yet, through a massive and enormously well-financed lobbying effort, physicians recently came perilously close to accomplishing passage of federal legislation exempting the established professions from FTC jurisdiction.[23]

Despite recent efforts on both federal and state levels to promote competition in the medical establishment, the profession has been largely successful in staving off threats to its monopoly power. Eliminating state licensing requirements, however, would be an effective strategy. Delicensure would permit competitive market forces to control health care costs and provide the additional benefits of better care and greater consumer choice. Moreover, it might have consequences of direct benefit to practitioners themselves.[24]

III. THE DISADVANTAGES OF LICENSURE

In light of the enormous cost of medical care it is important to consider whether the intended benefits of licensure, if they have indeed materialized, outweigh its costs.

The argument for licensure is comprised of two elements. First, consumers of medical services are considered simply too ignorant to protect themselves from the harmful, even fatal consequences of seeking help from quacks, frauds and charlatans.[25] Second, it is believed that the most effective way to protect consumers from their own poor judgment is to restrict their range of choice by means of a system of licensure.[26]

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[19] Wing & Craige, *Health Care Regulation: Dilemma of a Partially Developed Public Policy*, 57 N.C.L. REV. 1165, 1166 (1979).

[20] American Med. Ass'n v. FTC, 455 U.S. 676 (1982), *reh'g denied* 456 U.S. 966 (1982).

[21] *See, e.g.*, Medical Serv. Corp. of Spokane County, 88 F.T.C. 906 (1976); Forbes Health Sys. Med. Staff, 94 F.T.C. 1042 (1979).

[22] *In re* Michigan State Med. Soc'y, TRADE REG. REP. (CCH) ¶ 21,991 (1983).

[23] The McClure-Melcher bill was tabled in the Senate, 128 CONG. REC. S15,069-80 (daily ed. Dec. 16, 1982).

[24] *See infra* notes 79-82 and accompanying text.

[25] Hogan, *The Effectiveness of Licensing: History, Evidence, and Recommendations*, 7 LAW & HUM. BEHAV. 117, 117 (1983).

[26] *See* Frech, *supra* note 13, at 47.

Through limiting lawful practice to practitioners who have met the "minimum standards" set by the medical profession, licensure is supposed to protect "the sick and injured against exploitation by unqualified practitioners . . . ."[27] State licensure authorities are responsible for assuring that physicians are capable of practicing in a "satisfactory manner."[28] Although each state has different licensure requirements, three universal qualifications are: "[t]he high moral and ethical character of the candidate, the successful completion of the medical curriculum of an approved medical school, and a passing grade on a licensure examination."[29] Thus, it is the combination of medical school training and medical board regulation which is supposed to ensure maintenance of minimum standards in the general practice of medicine.[30]

Licensure, however, has not produced the desired gains in the quality of health care, in large measure because the profession itself controls the licensure mechanism. A growing body of evidence indicates that the profession's record for effectively policing itself has been less than stellar.[31] There is also concern that any benefits attributable to licensure have not persisted. On the one hand, medical schools and licensing boards successfully bar entry to individuals who lack the basic technical skills for competent practice;[32] yet, once a person is admitted, medical boards are far less effective at monitoring a physician's continued competency.[33]

Unlike other systems of credentialing, such as certification,[34] licensure not only sets standards of practice, but also excludes from the market practitioners who do not meet these standards. Under a system of certifica-

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[27] Annas, *The Case for Medical Licensure,* 8 MEDICOLEGAL NEWS 20 (1980). *See also* A. MORITZ & R. MORRIS, HANDBOOK OF LEGAL MEDICINE 134-35 (1970); R. DERBYSHIRE, *supra* note 3. *But see* Baram, *Managing Risks to Health, Safety and Environment by the Use of Alternatives to Regulation,* 16 NEW ENG. L. REV. 657, 663-64 (1981).

[28] Holden & Levit, *Medical Education, Licensure and the National Board of Medical Examiners,* 303 NEW ENG. J. MED. 1357, 1358 (1980).

[29] Cramblett, *National Policies for Medical Licensure Through the Federation of State Medical Boards,* 303 NEW ENG. J. MED. 1360 (1980).

[30] *Id.*

[31] *See* Hogan, *supra* note 25, at 121-33; F. GRAD & N. MARTI, PHYSICIANS LICENSURE AND DISCIPLINE: THE LEGAL AND PROFESSIONAL REGULATION OF MEDICAL PRACTICE 115-116, 126, 128, 130 (1979).

[32] *Id.* at 74-139.

[33] "At the present time, recertification programs have had little effect on physician competence. Specialty boards are the primary regulators of competence in medical specialties, but only four have active recertification programs, and two of these programs are voluntary . . . ." *Id.* at 95. "The failures of effective enforcement and of physicians to report the improper practices of colleagues both reflect certain self-protective professional attitudes." *Id.* at 115.

[34] *See* Havighurst & King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective* (pt. 1), 9 AM. J.L. & MED. 132-33 (1983); *see also infra* notes 70-71 and accompanying text.

tion, such as that which presently exists for medical specialties, the consumer is allowed to decide for himself whether to take his medical problem to a licensed physician who is a certified specialist or leave it to one who is a general practitioner. But it is a crime for someone who has not been licensed as a physician to deliver medical services which the licensure laws reserve to physicians. In practice, this has meant that consumers may not select, for example, the services of nurse-midwives over those of obstetricians or the services of nurse-practitioners over those of general practice physicians unless the nurse is willing to risk fine, imprisonment, and loss of the limited license to practice as a nurse.[35]

Licensure also inhibits experimentation with alternative modes of delivering medical services. These may be experimental, unconventional or simply unorthodox. Competition from these alternative modes could decrease the costs and, perhaps, increase the quality of medical services.

Consider the case of *Andrews v. Ballard,*[36] a class action by a group of consumers in Texas charging that the State Board of Medical Examiners had unconstitutionally infringed upon the plaintiffs' right to choose acupuncture as a form of therapy. *Andrews* dramatizes the effectiveness of licensure as an anticompetitive device. Prior to 1974, acupuncture practitioners had been available to consumers in Texas, because the Texas Medical Licensing Board had not applied the broad language of its medical practice act[37] to the practice of acupuncture. But in the early 1970's, when consumers displayed a growing interest in acupuncture, the American Medical Association and the licensing board took steps to protect licensed physicians from increased competition.[38]

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[35] *See, e.g.,* MASS. GEN. LAWS ANN. ch. 112, § 74A (West 1983). The certification requirements and limits of nursing practice are interpreted by the Massachusetts Board of Nursing Discipline and Registration to mean that a nurse could have her license revoked if she were discovered to be practicing medicine. Nurses are limited in their practice to counseling, advising, and implementing orders and medication prescribed by physicians, dentists and podiatrists, and must work under the supervision of a physician. Telephone interview with Eleanor Burke, Executive Secretary, Commonwealth of Massachusetts Board of Nursing Discipline and Registration, in Boston (March 1, 1983).

[36] 498 F. Supp. 1038 (S.D. Tex. 1980).

[37] Any person shall be regarded as practicing medicine within the meaning of this law: (1) who shall publicly profess to be a physician or surgeon and shall diagnose, treat or offer to treat, any disease or disorder, mental or physical, or any physical deformity or injury, by any system or method, to effect cures thereof, (2) or who shall diagnose, treat, or offer to treat any disorder, mental or physical, or any physical deformity or injury by any system or method and to effect cures thereof and charge therefor, directly or indirectly, money or other compensation . . . .

Id. at 1039 n.3.

[38] *Id.* at 1041 n.9. The text of the AMA resolution read:

Resolved, that it is the current judgment of the American Medical Association that since the practice of acupuncture in the United States is an experimental medical procedure it should be performed in a research setting by a licensed physician or under his direct supervision and responsibility, and therefore the AMA urges its

> On December 2, 1974, the board issued a policy statement which announced that acupuncture constituted the practice of medicine within the meaning of the Texas Medical Practice Act; that acupucture was an "experimental procedure," the safety and effectiveness of which had not been established; that although "acupuncture practice by licensed physicians not be absolutely prohibited, safeguards" were necessary to protect the public; that the practice of acupuncture by anyone who was not a licensed physician would constitute the unlicensed practice of medicine; and that any licensed physician delegating the authority to perform acupuncture to an unlicensed person would be subject to action against his license for unprofessional conduct and the lending of a license to practice medicine.[39]

In October, 1975, the board disciplined two physicians who had allowed non-physicians to practice acupuncture under their supervision. The board initially ordered cancellation of the physicians' licenses to practice medicine, but later reduced the sanction to ten years probation.

The Federal District Court for the Southern District of Texas declared the state board's actions unconstitutional in light of the burden which they placed on the plaintiffs' right of privacy. The court recognized that Texas could regulate the practice of acupuncture because of the state's interest in its citizens' health and well-being. The court went on to say:

> [Texas] is well-advised to protect that interest by assuring that both formally trained and formally untrained practitioners know what they are doing. That, however, is not what Texas has done. It has prohibited the formally trained from practicing, but has allowed [to practice] the formally untrained, who it admits "are not schooled enough in acupuncture to effectively supervise acupuncturists."[40]

The Board had seized for the medical profession the sole power to practice acupuncture, though not a single physician in the state of Texas had the competence to practice it. Consumers were foreclosed from the opportunity to seek services from trained acupuncturists because acupuncturists were not licensed physicians.[41] In effect, the board had effectively denied

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constituent state and territorial associations to seek appropriate legislation and rules and regulations to confine the performance of acupuncture to such research settings.

Resolution 55, House of Delegates of the American Medical Association.

[39] 498 F. Supp. at 1040-41. In January, 1976, the board formally reconsidered its December, 1974 policy statement in response to claims that it could not rule by way of such statements. Although it took no evidence and heard no testimony, the board reissued the statement as a set of formal rules having the force of law. *Id.*

[40] *Id.* at 1055.

[41] *Id.* at 1056.

Texas consumers the opportunity to obtain acupuncture from anyone. This, the court held, overly burdened the consumer's right to choose among medical therapies—a right encompassed by the constitutional right of privacy.[42]

While *Andrews* prohibited the complete foreclosure of a field of practice to those trained in that practice, licensure boards may still favor traditional practices and limit or hinder the development of alternatives. In this way, boards continue to protect physicians from competition. And, as the facts which precipitated *Andrews* indicate, medical professionals are willing to take action to ensure that protection.[43]

Andrews v. Ballard illustrates how the licensure monopoly insulates the medical profession from the healthy influences of consumer preference which would operate in a more competitive system. The mastery of medical science and technology which brought allopathic medicine its brilliant success and ascendancy in the late nineteenth and early twentieth centuries has arguably become a monomania which is now producing failure and decline. In its eagerness to embrace science, the profession has abandoned important aspects of medical practice which are more art than science. In many cases, the result has been to produce sickness rather than to cure it.

A major part of the old medical art was to think of the patient as a whole human being and to realize that the patient's sense of well-being was as much a function of the physician's accessibility, compassion, honesty and respect as it was a function of medical science. It was part of the old medical art to realize that the majority of illnesses were properly left to run their course without aggressive treatment. What the patient needed was to be put at ease, to be educated as to self-care, and to be told that the physician was available if further palliative or curative steps became appropriate.

The new medicine is so scientific, technological, and specialized that the patient as a whole is ignored, and the narrow illness complained of becomes an enemy that must be stamped out at all costs. One result is that the physician becomes responsible for producing an alarming amount of iatrogenic illness in the patients he is trying to cure.[44] The side effects of aggressive treatment with drugs, surgery or hospitalization have produced what some have called "iatrogenic epidemics."[45]

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[42] The plaintiffs have a constitutional right, encompassed by the right of privacy, to decide to obtain acupuncture treatment. The challenged articles and rules effectively deprive them of that right, and are not necessary to serve the State's interest in protecting the patient's health. That being so, they cannot stand.

Id. at 1057.

[43] *See, e.g.,* Arizona v. Maricopa County Med. Soc'y, 102 S. Ct. 2466 (1982) (physicians' maximum price-fixing plan struck down as an antitrust violation).

[44] "Iatrogenesis" is "the production of disease by the manner, diagnosis or treatment of a physician or some other member of the health care team." Editorial, *Iatrogenesis: Just What the Doctor Ordered,* 5 J. OF COMMUNITY HEALTH 149, 149 (1980).

[45] Sartwell has catalogued a series of iatrogenic empidemics over the past 50 years. A

Today's consumers of medical services appear increasingly ready to assume a greater role in shaping medical practice through the exercise of intelligent choice. They may not be as willing as they were at the end of the nineteenth century to trade their autonomy for the promised benefits of medical science and technology. These benefits, after all, may have reached a point of diminishing returns. The string of medical breakthroughs achieved earlier in this century may have led consumers to believe that the ultimate defeat of illness was inevitable if only the medical profession were granted sufficient autonomy, money, and time. This abiding faith may have peaked on April 12, 1955, when researchers at the University of Michigan announced the success of the Salk vaccine.

> "More than a scientific achievement, the vaccine was a folk victory," observes Richard Carter in his biography of Jonas Salk. "People observed moments of silence, rang bells, honked horns, blew factory whistles, fired salutes, kept their traffic lights red in brief periods of tribute, took the rest of the day off, closed their schools or convoked fervid assemblies therein, drank toasts, hugged children, attended church, smiled at strangers [and] forgave enemies." The magic of science and money had worked. And if polio could be prevented, Americans had reason to think that cancer and heart disease and mental illness could be stopped, too. Who knew how long human life might be extended? Medical research might offer passage to immortality. Between 1955 and 1960, unswerving congressional support pushed up the NIH budget from $81 million to $400 million.[46]

Since that time, the continually rising star of the medical profession has stumbled and stalled. The amount of money lavished upon the profession has continued to increase astronomically, but the promise of commensurate benefits seems unfulfilled. Despite frequent discussion of imminent breakthroughs, cancer has not been stopped. At one point cancer was becoming so prevalent that there was talk of a cancer "epidemic."[47] Heart

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computerized listing of medical journal citations on iatrogenic reports on surgery and drugs over a 30-month period uncovered almost 200 articles. They read like a shelf of gothic novels, a testimony to Murphy's law. One dramatic description of the extent of iatrogenic illness notes that the number of deaths and nonfatal hospitalizations directly attributable to medical intervention equals or exceeds the average number of deaths and nonfatal casualties from either the Korean or Vietnam wars.

Editorial, *supra* note 44, at 149; *see also* I. ILLICH, MEDICAL NEMESIS 270-71 (1976).

[46] P. STARR, *supra* note 8, at 347 (quoting R. CARTER, BREAKTHROUGH: THE SAGA OF JONAS SALK (1966)).

[47] According to present rates, about 66 million Americans now living, or about 30 percent of the population, will eventually have cancer. It was estimated that in 1983 about 855,000 people would be diagnosed as having cancer. AMERICAN CANCER SOCIETY, CANCER FACTS AND FIGURES: 1983, at 3 (1982).

disease also has not been cured. Indeed, the public's attention has been diverted towards methods of dealing with cancer, heart disease, and other threats to health which had been ignored and disparaged by a technology-prone profession. These methods seek to treat disease through changes in nutrition, environment, exercise, and life-style.

During the same period a consumer rights movement, combined with proliferation of lawyers in the United States,[48] has helped to increase the incidence of medical malpractice litigation. Shocked to discover that physicians were not the faultless miracle workers that the public believed them to be, jury after jury has awarded extraordinarily large sums in damages to patients injured iatrogenically. Reports of such cases in the media have provided the general public with an opportunity to share in the sense of shock and betrayal. It has become increasingly clear that blind allegiance to the medical profession provides no guarantee of good health.

The results of this increased consumer involvement in health decisions and disaffection with the medical profession are apparent. Consumers of medical services no longer believe that medical science is beyond their ken. The nineteenth-century disposition towards the profession is returning: consumers feel increasingly able to take responsibility for their own health and are more willing to take on the challenge of that responsibility. The new "holistic" medicine, which focuses on the "whole health" of the "whole person," epitomizes consumers' heightened personal commitments to their own well-being.[49]

Consumers today are better informed and better able to make their own medical decisions. "Informed consent" rules have provided consumers with the right to learn more from their doctors about their own health.[50] Educational opportunities in the United States have proliferated in recent years.[51] The G.I. Bill of Rights which followed World War II began a trend making higher education available to the masses;[52] greater numbers of

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[48] Law school enrollment in ABA-approved schools rose from 40,381 in 1960 to 82,041 in 1970, and 122,860 in 1979. AMERICAN BAR ASSOCIATION, REVIEW OF LEGAL EDUCATION.

[49] *See* Miller & Kellman, *How to Choose a Holistic Practitioner,* WHOLE LIFE TIMES, NOV., 1983, at 28.

[50] Informed consent rules provide a strong incentive to physicians to explain procedures and potential effects and side effects. *See* B. HOSFORD, MAKING YOUR OWN DECISIONS 158, 159, 174-176 (1982).

[51] AM. ACAD. POL. SCI. ANN. 96-122, 453 (1981); Warner & Lewis, *Trends in Education and Earnings, 1950-1970; A Structural Analysis,* 61 SOCIAL FORCES, Dec. 1982, at 436, 443-44. It is important to note here that the number of adults who have completed four years of high school or more has increased steadily and dramatically over the past 40 years. In 1950, 36% of adults had completed high school, while in 1981 the figure had increased to 70%.

[52] In 1939, 1,364,815 students were enrolled in four-year institutions of higher learning. U.S. DEP'T. OF HEALTH, EDUCATION AND WELFARE, FALL ENROLLMENT IN HIGHER EDUCATIONAL INSTITUTIONS (1954). By 1954, enrollment had risen to 2,499,750, *id.*, and, by 1960, to 3,610,007. U.S. DEPT. OF HEALTH, EDUCATION AND WELFARE, OPENING [FALL] ENROLLMENT IN HIGHER EDUCATIONAL INSTITUTIONS (1960).

people now achieve educational parity with the doctors who treat them. Television has extended its reach into virtually every living room, and medical themes have pervaded television programming. Consumer advocates have employed television and other media to raise viewers' understanding of medicine. Popular magazines such as *Prevention* and *Medical Self-Care,* dealing exclusively with health, abound. Bookstores have established separate "Personal Health" sections in order to accomodate the ever-growing consumer interest.

Upon close examination, then, the justifications for licensure are unpersuasive. Licensure fails to protect consumers who, for the most part, are able to protect themselves. More importantly, current licensure schemes have significant anticompetitive effects.[53] Licensure restricts consumer choice by foreclosing potentially beneficial health care options, and increases health care costs without providing increased quality.

If licensure were ever justified as a means of improving medical care, it can no longer be so justified. Delegating medical decisions to physicians may once have been needed to improve public health, but what is needed now is the return of decision making power to the patient. Denying the patient that power also denies patients the care which they want, deprives them of alternative therapies and inflicts avoidable iatrogenic illness. The patient who cannot choose for himself is also denied the realization of the physical and psychological benefits which flow from having the patient feel responsible for his health.

The near future will offer consumers of health care more powerful self-education and reference tools than ever before. Computer software has been developed to assist health professionals with diagnosis and treatment.

> In medicine, the computer which started by keeping records and sending bills, now suggests diagnoses. CADUCEUS knows some 4,000 symptoms of more than 500 diseases; MYCIN specializes in infectious diseases; PUFF measures lung functions. All can be plugged into a master network called SUMEX-AIM, with headquarters at Stanford in the West and Rutgers in the East .... The process may sound dehumanized, but in one hospital where the computer specializes in peptic ulcers, a survey of patients showed that they found the machine "more friendly, polite, relaxing and comprehensible" than the average physician.

Friedrich, *Machine of the Year: A New World Dawns,* TIME, January 3, 1983, at 14, 21. *See also* Pauker & Kassirer, *Clinical Decisions Analysis by Personal Computer,* 141 ARCH. OF INTERN. MED. 1835 (1981); Gorry, *The Personal Computer and Clinical Practice,* 141 ARCH. OF INTERN. MED. 1745 (1981). The technology already exists for making these programs available to health care consumers through low-cost personal computers with modem connections via telephone. "Estimates for the number of personal computers in use by the end of the century run as high as 80 million." Friedrich, *supra* at 16. A poll conducted for *Time* magazine in December, 1982 revealed that nearly four out of five Americans "expect that in the fairly near future, home computers will be as commonplace as television sets or dishwashers." *Id.* at 14.

[53] *See supra* notes 12-13 and accompanying text. *Contra* WHITE, PUBLIC HEALTH AND PRIVATE GAIN 17-24, 120 (1979).

IV. LIFE WITHOUT LICENSURE

Can medical licensure systems be abandoned? At first blush one might think that the chances look slim. The twentieth century has witnessed the development of an intricate set of interlocking institutions for the delivery of medical services which would complicate any movement toward delicensure.

Two potential sources of complication are the insurance industry and hospitals. Insurers, such as Blue Cross and Blue Shield, underwrite the majority of medical bills in the United States.[54] Only certain categories of providers of health care have been recognized as eligible for such reimbursement, and "for many non-M.D. practitioners licensure has been the first hurdle of many hurdles along the road to . . . third-party reimbursement."[55] If licensure were abandoned, insurers might persist in restricting the consumer's freedom of choice by refusing payment eligibility to disfavored provider categories. The consumer who is free to choose a nurse-midwife over an obstetrician, but only at the cost of giving up third-party reimbursement, is likely to feel less than truly free to choose.

Similarly, delicensure efforts are complicated by the central role hospitals play in twentieth century health care. Hospitals may refuse privileges to disfavored categories of providers, and thereby deny consumers the opportunity to receive certain kinds of health services in a hospital setting. Even the hospital privileges of licensed physicians are sometimes withdrawn to discourage nonconformist behavior.[56]

In a deregulated environment, however, both insurers and hospitals would have incentives to recognize non-M.D. practitioners. These incentives could conceivably outweigh the tendency to discriminate in favor of physicians. Providers could increase efficiency by delegating medical tasks to lower-cost personnel within traditional practice areas, as well as experimenting with new or unconventional therapies. Likewise, insurers could favor methods of health care delivery which improve the ratio of cost to

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[54] Payton & Posner, *Regulation Through the Looking Glass: Hospitals, Blue Cross and Certificate-of-Need,* 79 MICH. L. REV. 203, 227-28 (1980). *See also* Heitler, *Antitrust and Third Party Insurers,* 8 AM. J.L. & MED. 251, 252 (1982).

[55] J. Thompson, Trends in the Third Party Reimbursement for Non-Physician Health Care Providers, at 1 (paper delivered at the Licensing and Credentialing of Health Care Providers Conference, American Society of Law and Medicine, October, 1982).

[56] (O)bstetricians at Yale-New Haven Hospital were advised that their admitting privileges would be revoked if they attended non emergency home births . . . . The reason for the prohibition was obvious: the physicians and hospital wished to squelch competitive and threatening new modes of delivering care by manipulating admitting privileges.

Dolan, *The Law and the Maverick Health Practitioner,* 26 ST. LOUIS U.L.J. 627, 645 (1982).

perceived benefit. They might offer a range of policies which reimburse alternate treatments or alternate personnel for identical illnesses at a range of prices. The price of each policy would be a function of the cost savings that the insurer believed it would experience as a result of using different personnel and institutions to provide the care.[57]

One such policy might require that the consumer take his medical problems in the first instance to a nurse-practitioner. The nurse-practitioner would refer the patient to a physician only in those cases where the problem was beyond the nurse's independent practice competence. Cost savings would result from having such care delivered by nurse-practitioners instead of physicians because the former are paid substantially less than the latter for their services. Nurses also would be much less likely than physicians to feel obliged to respond to simple complaints with costly and risky drugs and therapy,[58] and much more likely than physicians to educate the patient with respect to methods for preventing illness from recurring.[59] Nurses would tend to deliver higher quality medical care in a manner more responsive to the patient's needs for reassurance, instruction in self-therapy, education as to etiology, diagnosis, and prognosis, compassion and continuing advice.[60] The demonstrated cost-effectiveness of nurse-practitioners, nurse-midwives, physicians' assistants, and other

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[57] To some extent, such options are already offered to consumers. At Boston College, for example, faculty and staff are currently offered a choice of six health care plans, including five health maintenance organizations (HMOs) and Blue Cross-Blue Shield. If an employee chooses an HMO (Harvard Community Health Plan, Lahey Clinic, Multi-Group, Tufts Associated, or Bay State), the university contributes the same dollar amount that would be applied to the corresponding Blue Cross premium. An employee selecting the Harvard Community Health Plan (HCHP) need only make a contribution of one dollar per month for individual coverage, as contrasted with $21.25 for Blue Cross-Blue Shield. The employee's monthly premium for family coverage under the HCHP is $43.47 as contrasted with the Blue Cross-Blue Shield monthly premium of $99.51. The price differential results from the somewhat more restrictive approach of the HMOs, which, unlike Blue Cross-Blue Shield, limit the patient's choice of primary care physician and use of specialists. HMOs also tend to discourage patients from using hospital emergency rooms by requiring those seeking medical attention after working hours to call the HMO. Usually patients are counseled to wait until the following day to visit an HMO, or are directed to an HMO evening facility. If emergency room care is necessary, the HMO generally directs the patient to a designated hospital.

[58] Nurse-midwifery is becoming increasingly popular and its benefits cannot be underestimated.

> Avoidance of unnecessary intervention in the birth process, with modern technology immediately available when really needed, may produce better perinatal outcomes by eliminating many iatrogenic problems.

Stewart & Clark, *Nurse-Midwifery Practice in an In-Hospital Birthing Center*, J. OF NURSE-MIDWIFERY, May/June, 1982, at 21, 25.

[59] Fagin, *Nursing as an Alternative to High-Cost Care*, AM. J. NURSING, Jan. 1982, at 56, 58.

[60] *Id.; see also* Ramsay, McKenzie & Fish, *Physicians and Nurse Practitioners: Do They Provide Equivalent Health Care?*, 72 PUBLIC HEALTH BRIEFS 55 (1982).

non-M.D. health-practitoners[61] would promote the reduction of costs, and heighten patients' perceived satisfaction.[62]

The use of new or unconventional therapies would also increase in a deregulated environment. The potential cost savings would provide hospitals with an incentive to liberalize staff privilege policies which might otherwise stand in the way of reform. Insurers of health care might find it to their advantage to recognize and reimburse previously prohibited forms of practice.

It might be argued that a greater use of non-M.D. practitioners in either traditional or nontraditional practice areas would produce a greater risk of malpractice liability. Over the last twenty years, hospitals have found themselves increasingly vulnerable to malpractice liability for the acts of their medical staff.[63] With the gradual erosion of the doctrine of charitable immunity, hospitals have become liable for the malpractice of their employees.[64] Under a variety of theories, they have become liable as well for the malpractice of non-employee medical personnel who possess staff privileges.[65]

To some extent, however, hospitals could tailor their experiments in non-physician practice without inordinate risk of malpractice exposure. In medical malpractice cases, practitioners are held to a standard of care which reflects the knowledge and skills of their particular practice group;[66] thus, nonphysicians are not held to the same duty of care as physicians. In a recent nursing malpractice case in California, for example, the court judged the adequacy of a nurse's performance "with reference to the performance of other nurses."[67]

Thus, a hospital should be able to afford itself maximum protection from exposure to malpractice liability by making clear to patients precisely what sort of practitioner will be treating them. Where nothing is said, the hospital is quite properly held to the standard of what the reasonable patient would be likely to expect in the absence of notice of special circumstances. On the other hand, where a hospital makes clear to a competent, consenting patient that non-emergency primary care is being delivered in an out-patient clinic by a nurse practitioner, or other practitioner, and not a

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[61] Tom, *Nurse Midwifery: A Developing Profession,* 10 LAW, MED. & HEALTH CARE 262 (1982).

[62] Precisely such practices are now being employed in some free-standing "minor emergency clinics." *See, e.g.,* Martin, *The Emergency Care Controversy: Can the New Clinics Pass the Physical?,* MEMPHIS, Sept., 1982, at 81.

[63] IIA HOSPITAL LAW MANUAL, *Principles of Hospital Liability,* ¶ 1-2 (1981).

[64] IIA HOSPITAL LAW MANUAL, *Immunity,* ¶ 2-7 (1982).

[65] IIB HOSPITAL LAW MANUAL, *Principles of Hospital Liability,* ¶ 4-1 (1983).

[66] W. PROSSER, HANDBOOK OF THE LAW OF TORTS, 161-62 (4th ed. 1971) (citations omitted).

[67] Fraijo v. Hartland Hosp., 99 Cal. App. 3d 331, 160 Cal. Rptr. 246, 252 (Cal. Ct. App. 1979).

physician, the standard of care should be that applicable to the particular practitioner's speciality,[68] and not that applicable to physicians. Such a result is consistent with the modern informed consent doctrine, which requires that patients be informed of "all the facts, risks and alternatives that a reasonable man in the situation which the [hospital] knew or should have known to be the plaintiff's would deem significant in making a decision to undergo the recommended treatment."[69]

Delicensure would provide strong incentives for increased education of the public about the risks and benefits of various medical therapies. The insurer who wished to sell medical insurance policies to prospective buyers would want to explain why the reduced cost achieved through the use of nurse-practitioners and other nonphysician health care professionals would not bring with it reduced quality of care. The same is true of the hospital that wished to compete in the market by employing non-M.D. professionals. Moreover, the hospital and the individual health practitioner who wished to maximize protection from malpractice would want to explain in as much detail as seems reasonably necessary how they are and are not holding themselves out to the individual consumer. The consumer also would be told what, if any, additional risks he might be running by consenting to unconventional treatments, and then could balance the relative risks and benefits.

Public education and informed consent would be further enhanced in their role of protecting the consumer interest by a widespread system of health practitioner certification. Such a system holds the potential for doing better than licensing much of the work which licensing was designed to do while avoiding licensing's major pitfalls.

Under a voluntary system of private certification, the various certifying groups would have a direct financial and professional stake in acting intelligently and responsibly. Unlike state licensing boards, private certifying groups would face competition. If there were a number of different certifying groups, the value of each certificate would depend upon the standards of the group. Neither doctors nor patients would attach much importance to gaining certification from a group with lax, vague, or unsound standards.[70]

Through public promulgation of their standards, certifying groups could make clear what skills and results they were holding themselves out as offering—thus providing the consumer with a generalized basis for

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[68] Such a standard of care would reflect the expectation, for example, that a nurse-practitioner know, among other things, when to refer a patient to a phyisician.

[69] Cooper v. Roberts, 220 Pa. Super. 260, 267, 286 A.2d 647, 650 (1971).

[70] Locke, Mode & Binswager, *The Case Against Medical Licensing*, 8 MEDICOLEGAL NEWS, Oct. 1980, at 13-14.

determining when malpractice had occurred.[71] Health practitioners certified by a particular group could have certification revoked if they regularly departed from the standards of the certifying group. But even if the government required that every health practitioner be certified by one group or another, the result need not be as repressive as that under licensing. New practitioners would be free to establish their own new certifying group, with standards that reflected their own approach to health care, and the consumer of health services would be free to choose between the new group's practitioners and those of the certifying groups with which it competed.

Another important effect of delicensure is that the medical consumer who must choose for himself is likely to be more healthy. People who must make decisions for themselves become better at making decisions. As Mill observed:

> He who lets the world, or his own portion of it, choose his plan of life for him has no need of any other faculty than the ape-like one of animation. He who chooses his plan for himself employs all his faculties. He must use observation to see, reasoning and judgments to foresee, activity to gather materials for decision, discrimination to decide, and when he has decided, firmness and self-control to hold to his deliberate decision.[72]

Experience of the last few years under a legally-mandated regime of

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[71] The personal representative of the estate of a deceased minor claimed that the minor's death was caused by the negligence of two Christian Science practitioners who sought to treat the minor according to the practices of the Church. The plaintiff alleged as one ground for tort recovery against the Christian Science Church the physicians' departure from the Church's own medical standards. The plaintiff claimed:

> 65. That defendants owed a duty to the plaintiffs to perform their practitioner work in accordance with the rules and regulations of the Christian Science Church.
> 66. That the defendants breached that duty in the following particulars:
> (a) That neither defendants reported the case of Matthew Swan to the Committee on Publication.
> (b) That defendant, June Ahearn, failed to frequently visit Matthew Swan.
> (c) That neither practitioner saw to it that Matthew Swan's case was reported to the local health official.
> (d) That defendant, Jeanne Laitner and defendant, June Ahearn, owed a duty to send a Christian Science nurse with a card to assess Matthew Swan.
> (e) That defendants speculated, and thus engaged in diagnosing, as to the reason for Matthew Swan's problems, i.e., cutting a tooth, roseola, rheumatic fever and paralysis.
> (f) In failing to consult with a physician on the anatomy involved.
> (g) In failing to communicate to the parents any change in Christian Science policy regarding medical treatment of minor children if in fact there had been one.

Complaint and Demand for Jury Trial, May v. Laitner, Mich. Cir. Ct., filed Feb. 5, 1980.

[72] J. S. MILL, *supra* note 6, at 56.

informed consent in medicine tends to bear out Mill's observation. Patients who are told that they have the ultimate power to choose among alternative therapies and are fully informed of the relative benefits and risks of each tend to grow to meet the challenge of the responsibility for choice.[73] Gradually, they begin to ask for additional information and to educate themselves from other sources.[74] An increased sense of health may be experienced by individuals simply through feeling in control of their lives and through being freed of the anxiety which results from believing that important information is being withheld.[75] Patients tend not to opt for clearly "medically irrational" alternatives.[76] Indeed, because they understand the rationale behind the prescribed course of therapy and feel themselves partners in the therapeutic enterprise, they tend to be more scrupulous in following the course of therapy prescribed.[77] Patients may even begin to show more concern for their health as a whole—giving up aspects of an unhealthy lifestyle because they are inconsistent with the enterprise of maintaining good health which the patient has now taken on as his own responsibility.

Delicensure would permit patients to choose from among a greater range of health care schools and systems. Patients would tend to assume greater responsibility than traditional patients for their own health care decisions.[78] Such heightened patient autonomy is central to the new "holistic" approach to medicine:

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[73] *See generally* Faden, Becker, Lewis, Freeman & Faden, *Disclosure of Information to Patients in Medical Care*, 19 MED. CARE 718 (1981); Denney, Williamson & Penn, *Community Medicine; Informed Consent: Emotional Responses of Patients*, 60 POSTGRAD. MED. 205 (1976); Alfidi, *Informed Consent: A Study of Patient Reaction*, 216 J. A.M.A. 1325 (1971).

[74] Mazis, Morris & Gordon, *Patient Attitudes About Two Forms of Oral Contraceptive Information*, 16 MED. CARE 1045 (1978); Pratt, Seligmann & Reader, *Physician Views on the Level of Medical Information Among Patients*, 47 AM. J. PUB. HEALTH 1277 (1957).

[75] *See* Denney, Williamson & Penn, *supra* note 73; Pemberton, *Diagnosis: Ca: Should We Tell the Truth?*, BULL. OF THE COLLEGE OF SURGEONS, March, 1971, at 11; Skipper and Leonard, *Children, Stress, and Hospitalization: A Field Experiment*, 9 J. HEALTH SOC. BEHAV. 275 (1968); Dumas & Leonard, *Effect of Nursing on the Incidence of Postoperative Vomiting*, 12 NURS. RESEARCH 12 (1963); Egbert, Battit, Turnadoff & Beecher, *The Value of the Postoperative Visit by an Anesthetist: A Study of Doctor-Patient Rapport*, 185 J. A.M.A. 553 (1963); Abram & Gill, *Predictions of Postoperative Psychiatric Complications*, 265 NEW ENG. J. MED. 1123 (1961).

[76] *See* Alfidi, *supra* note 73.

[77] *See* Faden, Becker, Lewis, Freeman & Faden, *supra* note 73, at 731; Korsch & Negrete, *Doctor-Patient Communication: Patient Response to Medical Advice*, 280 NEW ENG. J. MED. 535 (1969).

[78] Telephone interview with Stephen Rechstaffen, M.D., staff physician at the Rhinebeck Institute and president of the Omega Institute in Rhinebeck, New York (Dec. 14, 1983). This is not to say, however, that all persons who choose for themselves schools or systems of "alternative medical care" display readiness to take on an adult role in the physician-patient relationship. "Unfortunately, the classic relationship of medical authority figure and obedient patient . . . seems to repeat itself far too often among holistic practitioners and their clients. Individuals sometimes accept the most far-fetched remedies uncritically, putting themselves

> What we call "holistic" methods are really only "whole" when taken all *together*—as an array of options available to us. The only sane and reliable approach in getting effective help is to maintain a sense of responsibility for your own healing and well-being—using those elements of conventional American Medical Association medicine, unconventional and non-Western systems, and anything else that works and is appropriate at a given time. In the final analysis, there is only one practitioner who can have a truly holistic perspective on your health and your therapeutic needs—and that is yourself.[79]

Physicians, too, stand to benefit from delicensure. Not only patients, but also physicians suffer the negative consequences of the paternalism and dependency characteristic of conventional doctor-patient relationships. Though physicians attempt to persuade themselves that "the patient is the one with the disease,"[80] "burn-out" occurs even among the strongest physicians.[81] Many physicians complain that they are practicing medicine more and enjoying it less. If, as claimed, delicensure would produce more adult-to-adult, collaborative relationships between physicians and patients, physicians might well suffer less burn-out and derive greater satisfaction from their work.[82] Many physicians already recognize the potential benefits:

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unquestioningly in the hands of nutritionists, bodywork therapists, spiritual gurus, naturopaths, and chiropractors (to mention but a few)—wanting them to be all-knowing and magically effective." Miller & Kellman, *supra* note 49, at 28.

[79] Miller & Kellman, *supra* note 49, at 29. As part of their general "consumerist approach," the authors advise:

> Don't be afraid of disappointing or insulting the caregiver with your questions or decision. The practitioner should not act or be treated as someone who is superior to you, or has any special power. He is simply someone who has particular expertise and information that you may want. You are your own healer; the practitioner is your assistant. (Research is beginning to appear showing that cancer patients who argue with their doctors and sometimes defy them recover more frequently than patients who are quiet and obedient.)

Id.

[80] S. SHEM, THE HOUSE OF GOD 129 (1978).

[81] M. FERGUSON, THE AQUARIAN CONSPIRACY: PERSONAL AND SOCIAL TRANSFORMATION IN THE 1980's, at 245 (1980).

[82] Under the paternalistic model, the physician-parent takes on ultimate responsibility for the health of the patient-child. Where the responsibility is shared on an adult-to-adult basis, the physician is able to feel more relaxed. His role is more limited and success is gauged by a different standard. He is not a guarantor of outcomes. The patient shares in the responsibility for the outcome, and the physician merely has to play as well as he can his role of expert counselor and technician.

In this connection, consider the example of a medical doctor in his early forties who opened a center for holistic health in Cambridge, Massachusetts in 1977. His patients realize that they take primary responsibility for their health and that he is basically a consultant and assistant in that enterprise. Much of his work is educational. He publishes leaflets on nutrition, vitamins, exercise, and preventive self-care, and distributes nutritional supplements and

so-called "lifestyle" medicine seems to be making its greatest inroads with the profession's youngest members.[83]

VI. CONCLUSION

The medical licensing laws are an intolerable anachronism. They are at the heart of the current medical care cost crisis, and are the foundation of a medical regime whose narrow technological focus causes it to forego rich opportunities to promote general physical and mental well-being. This narrow focus is linked to increases in iatrogenic illness.

Licensure also stands between consumers of medicine and their power to control their own health. If the paternalism inherent in such laws ever produced a net health benefit for consumers, it does so no longer. At the same time that medical licensure has offered less protection at greater cost, consumers have become better able and more willing to protect themselves.

Consumers of medical services are not passively awaiting change, but rather are organizing to bring it about. In a recent issue of *Prevention* magazine, the editor announced the formation of a "People's Medical Society" for the purpose of developing the political power needed to remove legal roadblocks on the path to complete medical autonomy:

> We have within us enormous power to create our own health. In fact, all but a tiny bit of true health is self-created by the way we learn to live and think. Yet we have abdicated much of our freedom to use self-created health power by adopting the attitude that medical care delivered from the outside is more powerful. That is just not true. So we need the People's Medical Society, and other organizations like it, to help build confidence in our ability to create new areas of health freedom for ourselves.[84]

High on the Society's political "hit list" are the medical licensure laws.[85]

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self-care books. He also examines, advises, and offers medical treatment to his patients. They do not always fully accept the proffered advice or treatment, but that is their choice. He believes that proper respect for the whole patient requires the doctor to allow the patient to decide his health questions for himself. This doctor works essentially from 9 to 5 and enjoys a full personal life along with his professional life.

[83] *New Physician*, the official publication of the American Medical Students Association, devoted an entire issue in 1977 to alternative practices and has a regular department on humanistic medicine. Laurel Cappa, who served as AMSA's president in 1976, told a physicians' convention of the students' interest in family practice and in nontraditional approaches such as meditation and Gestalt psychology. Medical students, she said, want to be partners, not authority figures, to their patients. M. FERGUSON, *supra* note 81, at 265.

[84] Editorial, *Let (Health) Freedom Ring!*, PREVENTION, Jan., 1983, at 12.

[85] In the same editorial that announced the formation of the Society, its founders called for repeal of licensure:

> Many of our most valuable health freedoms are limited by the medical practice acts of each of the 50 states and the District of Columbia. These laws were originally put on

Despite the potential benefits, the repeal of medical licensure laws is not likely to occur without massive resistance from the medical profession. The recent battle in Congress regarding FTC jurisdiction over the medical profession[86] is compelling evidence that the profession will not yield without a struggle the power, prestige, and monetary wealth which it has come to regard as its due. Repeal of licensure laws will occur only if consumers of medical services organize and work diligently to bring it about.

However, such a consumer movement has the potential for finding allies within the medical profession. There is, after all, a considerable overlap between the long term self-interest of physicians and that of their consumers.[87] As citizens, physicians benefit generally from changes in the social structure which benefit society as a whole. As health professionals, physicians benefit from any changes in health care delivery likely to produce better health for their patients. As persons, physicians stand to experience enhanced health and happiness from any departure from their paternalistic posture towards their patients. It is not unreasonable, then, to believe that some portion of the profession might ultimately welcome delicensure and other consumer health care initiatives.

> the books to set standards for the practice of medicine, and thereby protect the public from people calling themselves doctors who were poorly trained, or who had insufficient skill . . . .
>
> What you must care about is that all these laws protect a medical monopoly, which we never needed, and which we especially don't need now. There has been a turnaround. It is no longer the public that is primarily being protected by the medical-licensing acts. It is the doctors who are finding shelter behind them. And that shield takes money out of our pockets and takes the idea of health self-generation out of our heads.

Id. at 10-11. The Society has recently published a scholarly monograph which makes a strong case for major overhaul or repeal of medical licensing laws. *See* L. ANDREWS, DEREGULATING DOCTORING: DO MEDICAL LICENSING LAWS MEET TODAY'S HEALTH CARE NEEDS? (1983).

[86] *See supra* note 23 and accompanying text.

> [87] The Americans . . . enjoy explaining almost every act of their lives on the principal of self-interest properly understood. It gives them pleasure to point out how an enlightened self-love continually leads them to help one another and disposes them freely to give part of their time and wealth for the good of the state . . . . Every American has the sense to sacrifice some of his private interests to save the rest.

A. DE TOCQUEVILLE, *supra* note 6, at 498-99.

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